Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Providence Health Center

Respondent Name
Travelers Property Casualty Co

MFDR Tracking Number
M4-14-1592-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
January 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: $135.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgment of medical fee dispute received however, no written position submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2013	Outpatient Hospital Services	$135.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 45 – Charge exceeds fee schedule maximum allowable or contracted/legislated fee arrangement
   - W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Was the disputed service subject to CCI edit?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.403(d) states in pertinent part, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs." The National Correct Coding Initiative, Chapter 9(B), states in pertinent part, "CPT codes 96360…, describe "initial" service codes. For a patient encounter only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites." However, the description of the disputed service is, "96360 - Intravenous infusion, hydration; initial, **31** minutes to 1 hour." Review of the medical documentation shows total duration of administration was 0.5 or 30 minutes. Therefore, the submitted documentation does not support separate payment should be allowed as hydration lasting 30 minutes or less is not reported.
2. The total allowable reimbursement for the services in dispute is $539.64. This amount less the amount previously paid by the insurance carrier of $638.56 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.